Oral and Dental Aspects of Child Abuse and Neglect

Christine Park, December 2014

Key messages

- Poor oral and dental health can be part of the picture of child neglect.
- It is important that oral and dental health is assessed by an appropriately qualified dental professional as part of the overall assessment of a child's circumstances and needs.
- Injuries to the head and neck are found in approximately 60% of physical abuse cases.
- Intra-oral injuries have been noted in up to 30% of physical abuse cases.
- Dental caries is common but severe untreated dental decay is always a cause for concern.
- Untreated dental disease can result in severe pain, facial swelling or chronic infections. This can result in sleep disturbance, missed school or nursery, and poor oral function. This affects eating, speaking and social interaction. Chronic infection and oral pain also affect the child's growth and development.
- 91% of children in Scotland are registered with an NHS dentist who will have information about their attendance rates for routine recall examinations as well as treatment and emergency attendances.
- Information concerning a child's registration and engagement with dental services should routinely be collected by other services involved in the child's life.

Introduction

Currently 91% of children in Scotland are registered with an NHS dentist, with only two NHS boards having less than 85% of children registered with a dentist. In Scotland 86% of children will have seen their NHS dentist at least once within the past two years[1]. This equates to a large proportion of the child population in Scotland who will have had contact with dental professionals.

All children should be registered with a dentist at least by the time they have their first tooth (around 6 months of age) so a child not being registered with a dentist may, in itself, be a concern. Dental teams hold information about an important aspect of children's health, namely that of their oral health. No other health professional will have such detail, however oral and dental health is often not taken into account by other professionals who are seeking to identify whether or not a child's needs are being met. Dental teams may also be aware of concerning patterns of behaviour from children and their families. This could include failure to complete courses of treatment, or recurrent / frequent episodes of children only being brought to the dentist when they are in pain. It is, therefore, surprising that dental teams are not routinely consulted by other professionals who are seeking to establish whether a child's needs are being met. This briefing aims to explain the oral and dental aspects of child abuse and neglect so that other professionals will be aware of their importance.

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Why is this issue important?

Dental caries is one of the most common diseases of childhood but it is entirely preventable. It is also the most frequent reason that children in Scotland are admitted for a general anaesthetic. Failure to consider the oral and dental needs of a child in the assessment of their overall needs could result in an underestimate of those needs. A large proportion of the paediatric population of Scotland are registered with dental services but this information is often not collected or considered when assessing a child's needs.

What does the research tell us?

Dentist's involvement in recognising physical or sexual abuse

Studies of the prevalence of injuries to the head, face and neck of physically abused children consistently show that 50-75% of physically abused children have orofacial signs of abuse which would be obvious to a dental practitioner[2-6]. Orofacial signs of physical child abuse include bruising of soft tissues (especially those that do not overlie a bony contour), abrasions, multiple injuries, bruising of different vintages, scarring of the lips, dento-alveolar injuries, fractures, burns and "tattoo" injuries which reflect the shape of the offending object.

As many of these injuries can occur accidentally the history of injuries from parents/ guardians and the child themselves is vital. If the explanation for the injury does not fit with the clinical picture then the examining dentist should have a high index of suspicion of child abuse. The site of the injury is also important. Accidental injuries commonly involve bony prominences and should be in keeping with the development of the child, whereas injuries to soft tissues or injuries that would be unusual for the child's developmental stage are suspicious.

Dentists also have knowledge of the oral appearances of sexually transmitted infections and what tests are required to confirm or refute their differential diagnoses.

Dentists role in the recognition of neglect

The British Society of Paediatric Dentistry (BSPD) published guidelines on dental neglect in 2009. Their definition is "the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of a child's oral or general health or development."[7] Although dental caries (decay) is still common in children in Scotland signs such as failing to complete courses of dental treatment, failing to listen and act on preventive advice given by dental teams, children returning in pain repeatedly, children requiring repeated general anaesthetics due to dental issues or children who are repeatedly not brought to their dental appointments would all be concerning patterns of behaviour which are likely to result in the impairment of a child's oral or general health or development. For these reasons dentists should be involved in the recognition of neglect[7-9]. Untreated dental decay may be one of the first signs of child abuse or neglect[10]. Neglect should be considered if parents have access to, but persistently fail to obtain treatment for their child's tooth decay[11].

Dental caries in children is a global problem and the World Health Organisation has identified dental caries as one of their areas of concern. It has been shown that those children who are more deprived have higher caries rates than children from more affluent areas; however there is no association in Scotland between deprivation rates and registration with an NHS dentist although those children from deprived areas are less likely to have seen their dentist within the last two years. There has also been a relationship established between oral health and child maltreatment. The research suggests that abused/ neglected children are more likely to have untreated decayed teeth than non-abused/ non-neglected children and also have significantly more dental plaque and gingival inflammation [12-15].

The British Society of Paediatric Dentistry (BSPD) published guidelines on dental neglect in 2009
http://withscotland.org/resources/british-society-of-paediatric-dentistry-a-policy-document-on-dental-neglect-in-children

Implications for practice

Practitioners have a difficult job in assessing the needs of children they work with. Recording the details of the child and family's registration and engagement with dental services is imperative in assessing whether all of a child's needs are being met. General dental practitioners hold information on children's patterns of attendance and level of engagement with services. If there are any oral or dental conditions they feel are beyond their competence they can refer to the specialist paediatric dental services in the public dental service or hospital dental service. More engagement of practitioners with their local dental teams will also encourage more information sharing. Dental teams feel more confident referring children they are concerned about when they know who their local children protection and social services are. Practitioners need to be aware that severe untreated dental caries resulting in the impairment of a child's health and development can be the reason that a child is referred to their local social work department even when it appears that all their other needs are being met by their carers.

Sources of further information

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16. Child Protection for the Dental Team
    www.cpdt.org.uk

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